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Treating Crazy People Less Specially

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I. INTRODUCTION

Mental health laws treat mentally disordered people differently from other adults in virtually every area of civil and criminal law.[1] Some mental health laws provide a benefit the crazy person desires. Examples are the disordered person's opportunity to defeat a criminal prosecution by claiming legal insanity or to avoid a contract by claiming incompetence to contract. Other mental health laws, such as provisions for involuntary commitment and treatment, operate contrary to the crazy person's desires. In all cases, however, special legal treatment results from the assumption that crazy persons are not responsible for their behavior, an assumption buttressed by the mistaken and usually unanalyzed notion that mental disorder per se deprives people of responsibility.

The best recent example of the adoption of this incorrect assumption, "the common wisdom," is the United States Supreme Court's decision in *City of Cleburne v. Cleburne Living Center*,[2] which held that mental retardation is *not* a quasi-suspect classification. The Court rejected the argument that, under the Equal Protection Clause, laws that distinguish the retarded as a class should be subjected to particularly careful examination to determine if they substantially further an important governmental purpose. Although the case dealt specifically with retarded people, the majority recognized that its reasoning also applied to the mentally ill, and thus

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1. *See* S. BRAKEL, J. PARRY & B. WIENER, THE MENTALLY DISABLED AND THE LAW (3d ed. 1985).

2. City of Cleburne v. Cleburne Living Center, 473 U.S. 432 (1985).

the decision makes it easier for legislatures to distinguish the mentally disordered.

To support its holding, the Court determined that retarded people have "reduced ability to cope with and function in the everyday world."[3] Downplaying the history of discrimination and antipathy towards the retarded and their political powerlessness, the Court also concluded that:

> [S]ingling out the retarded for special treatment reflects the real and undeniable differences between the retarded and others. That a civilized and decent society expects and approves such legislation indicates that governmental consideration of those differences in the vast majority of situations is not only legitimate but . . . desirable.[4]

Although the Court recognized that retarded people differ substantially in their ability to cope and that the disabilities of some are not immediately evident, it refused to apply heightened scrutiny to laws that distinguish the retarded as a class.[5]

In sum, the law's present view is that great deference must be granted to legislative decisions to treat retarded and mentally disordered people specially because the retarded and the mentally disordered as entire classes are specially unable to cope with the demands of the world. Thus all mental health laws deprive allegedly crazy persons of the usual, dignity-conferring presumptions of responsibility and competence.

I suggest, however, that fewer crazy persons are nonresponsible and incompetent than is commonly supposed. The behavior of some crazy people surely satisfies the correct general criteria of nonresponsibility—irrationality and compulsion.[6] Nevertheless, the common wisdom is too sweeping; laypersons and mental health

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3. *Id.* at 422.

4. *Id.* at 444.

5. For a sensitive reading of *Cleburne* that distinguishes three approaches to treating classes of "different" people—"the 'abnormal persons' approach," the "rights analysis approach," and the "social relations approach"—*see* Minow, *When Difference Has Its Home: Group Homes for the Mentally Retarded, Equal Protection and Legal Treatment of Difference*, 22 HARV. C.R.-C.L. L. REV. 111 (1987).

6. Morse, *Psychology, Determinism, and Legal Responsibility*, in THE LAW AS A BEHAVIORAL INSTRUMENT: NEBRASKA SYMPOSIUM ON MOTIVATION 35, 59-71 (G. Melton ed. 1986).

professionals alike tend consistently to underestimate the capabilities of crazy people. Thus, even when the legal system tightens mental health law criteria and procedures, as it did for involuntary commitment in the 1970s, the law continues to ensnare large numbers of crazy people because decisionmakers guided by the "common wisdom" fail in practice to apply strictly the laws on the books. Even reformed laws sweep far too broadly because crazy people are far more responsible than is usually assumed. Finally, singling out crazy people for special legal treatment is often not the optimal means to achieve the social purposes that the behavioral components of mental health laws are meant to achieve.

II. Political and Moral Assumptions

The scope of mental health laws differs at various times; sometimes the law seems willing to treat many people specially and at other times the law treats few specially. Policy shifts can result from changes in political or social preferences, from changes in conclusions about the capabilities of crazy people, or, more probably, from some combination of both. But differing conclusions about the capabilities of crazy people do not logically entail political and legal changes. For example, assume that behavioral scientists were able rigorously to confirm that crazy people are substantially less able to behave rationally than we currently suppose. Assume further that the mentally disordered as a class were considered legally responsible in general prior to the new scientific findings. If the standards for legal responsibility did not shift, we might conclude that laws treating the disordered as less responsible were now justified. But if society simultaneously decided on moral and political grounds to lower the threshold for legal responsibility, the mentally disordered as a class might still be capable of meeting the general standards, and special laws would not be justified. Thus, the political and legal consequences that follow from an accurate view of the capabilities of crazy people depend on one's political and moral preferences.

Before assessing the capabilities of crazy people, it is therefore necessary to make explicit the moral and political preferences that inform my legal recommendations. I will not offer any foundational justification for these preferences because I do not believe such foun-

dations can be provided.[7] What I hope to offer instead is an internally coherent account that entails a strong preference for negative liberty and autonomy,[8] for respecting persons' stated, present preferences, for erring on the side of leaving persons alone to do as they wish, and for treating all persons alike and as responsible and competent citizens as often as possible.[9] I wish to examine the implications of applying these views to mentally disordered people. Now let me be more specific about the preference for liberty.

First, a preference for liberty entails the adoption of a non-ideal, "desire" theory of the good life that assumes that persons are the best judges of what is good for them and that there is no "true" good independent of a person's tastes, preferences, values and desires.[10] Pluralist liberal societies are based on such assumptions. Rationality or some minimalist conception of primary goods may constrain this view—some desires or preferences may be so outlandish, for example, that we are unwilling to credit the person as a rational being—but a non-ideal theory of the good life will emphasize a subjective view of the good and thus will insist on caution before we may claim that what a person prefers is not good for him. Unwanted personal or state intervention into another's life requires stronger justification according to a non-ideal theory than according to an ideal theory that defines the good independently of preferences as virtue, excellence, or achievement. The non-ideal view would presume strongly, but not conclusively, that the mentally disordered and the mentally normal alike know what is best for them.

Second, a preference for liberty entails the adoption of the related assumption that a person's true preferences or desires are those

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7. *See generally* D. HERZOG, WITHOUT FOUNDATIONS: JUSTIFICATION IN POLITICAL THEORY (1985).

8. My usage of negative liberty follows that most famously associated with Isaiah Berlin in his seminal essay, I. BERLIN, *Two Concepts of Liberty*, in FOUR ESSAYS ON LIBERTY xxxvii, 118 (1969).

9. My preferences most closely approximate what Martha Minow identifies as the "rights analysis approach." Minow, *supra* note 5, at 122-27, 153-57. Unlike Professor Minow, however, I do not believe that the rights analysis approach is inconsistent with a contextualist approach to knowledge or with the many benefits that might flow from the social relations approach. *Id.* at 184-86. For example, a redefinition of the significance of human traits to enhance relationships between people is consistent with a rights analysis approach. *See infra* text accompanying note 44.

10. On the distinction between "ideal" and "desire" theories of the good, *see, e.g.*, Brock, *Paternalism and Promoting the Good*, in PATERNALISM 237, 250-54 (R. Sartorius ed. 1983).

he or she claims, even if those preferences seem imprudent, harmful, or immoral. This subjective assumption strongly presumes that the person knows best what his or her preferences are. Conversely, this assumption rejects idealized, exalted metaphysical notions of a person's will, which hold that the person's "real" desires, despite his or her claims to the contrary, are those a hypothetical, ideally rational person might choose.[11] It also rejects claims that a person's real preferences are unconscious, psychodynamic wishes the person may be unable to acknowledge.[12]

Rejecting "ideal" or unconscious preferences as real preferences does not mean that a person's behavior is not sometimes foolish and is not on some occasions caused by unconscious psychological determinants. It does mean, however, that a person's stated preferences *are* his or her preferences, whether or not they seem "fully" rational and without regard to how they are caused. To assume otherwise is to deprive a person of integrity and autonomy. The subjective assumption that a person best understands his or her own preferences demands that great caution be exercised before permitting external observers to impose unwanted paternalistic impositions on the ground that the observer knows the person's "real" preferences better and is thus doing what the person "really" wants.

Third, a preference for liberty entails, either on consequential or nonconsequential grounds, the assumption that the deprivation of negative liberty is generally harmful. Whether treated as a deontological trump or as a thumb on the consequential scale, liberty is entitled to great and perhaps decisive weight. Liberty is so important that decisionmakers should be cautious either about depriving a person of the trump because he or she is nonresponsible or about overweighing other factors in a consequential balance.

Fourth, a preference for liberty entails the assumption that responsibility and competence should be treated as threshold rather

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11. On hypothetical rationality, *see* J. FEINBERG, 3 HARM TO SELF: THE MORAL LIMITS OF THE CRIMINAL LAW 184-86 (1986); J. KLEINIG, PATERNALISM 63-67 (1984).

12. *See* Morse, *Failed Explanations and Criminal Responsibility: Experts and the Unconscious*, 68 VA. L. REV. 971, 991-1039 (1982).

than relativistic concepts[13] and that the law should set the threshold quite low. If we think of responsibility and competence as distributed along a continuum, then in a sense everyone is less responsible or competent than people who are more so. Thus, in the abstract, the law could allocate liberty benefits proportionately to one's degree of responsibility and competence; more responsible and competent people would have more legal autonomy and liberty and vice versa along the continuum. This is the relativist concept. The alternative, threshold concept treats responsibility and competence as bright lines. Once a person exceeds the threshold, he or she is considered fully responsible or competent, and those on the other side of the threshold are treated as nonresponsible or incompetent.

The threshold concept, with the threshold set quite low, is preferable because it grants more autonomy and liberty to more people more of the time, thus treating more people as full persons worthy of dignity and respect. Although our society should not have unrealistic expectations and standards for our most mentally disabled citizens, most people should be considered responsible and competent. In other words, the law should not require an unrealistically high or ideal degree of rationality or ability in order to hold people responsible or competent. Indeed, if we consider the enormous amount of seemingly foolish, harmful, and otherwise poorly performed behavior we would not dream of preventing, it appears that the law already makes this assumption. Moreover, a threshold concept is far easier to devise and administer. Setting a low threshold for responsibility and competence again insures caution before treating any class of people as nonresponsible or incompetent.

None of the four assumptions is inviolable. For example, some people may be so irrational that depriving them of negative liberty in order to restore their responsibility and competence might be justified. Indeed, the primary justification for preferring negative liberty is that rational persons best know and can maximize their own

13. A helpful discussion of the distinction between the relativistic and the threshold sense of competence is, Wikler, *Paternalism and the Mildly Retarded*, in PATERNALISM 83, 85-91 (R.Sartorius ed. 1983).

desires. Nevertheless, strong theoretical and factual reasons would always be necessary to override the assumptions.

Why should anyone adopt the assumptions that I have enunciated as the components of a preference for liberty? As stated at the outset, I cannot provide an uncontroversial conceptual or empirical foundation for them. But I can ask you to try empathetically to imagine what society would be like if the law were constrained by these assumptions. Would more people be happy or satisfied or consider their lives worthwhile than if the law adopted a different vision? Stated another way, would more people, including the mentally disordered, flourish or be better off? We cannot know; we can only estimate, but most public policy is based upon such estimations. In making such an estimation, I believe it is appropriate to adopt the vantagepoint of late twentieth century Americans, with their values, predispositions, preferences, and knowledge of themselves and history. Although the Rawlsian vantage point of an ideally rational observer, unaffected by culture and history, is of course appealing, it is unlikely to help us make policy in light of who we are and who we might realistically become.

A final assumption crucial to proper mental health lawmaking is that the ultimate question in mental health law is always social, moral, political, and legal. Whether and according to what criteria people should be considered nonresponsible or incompetent are not medical, psychiatric, or psychological questions that can be coherently asked and answered in these terms. Mental health scientists and clinicians may in some instances be able to provide lawmakers with relevant data concerning the capabilities and behavior of crazy people, but the normative consequences of crazy behavior are not medical issues. Therefore, social and legal decisionmakers cannot abdicate their responsibility to decide normative issues by mistakenly assuming that the issues are medical rather than moral and legal.

Adopting the assumptions described—a preference for liberty and treating mental health law issues as legal—does not entail the further assumption that all adults or classes of adults must be deemed responsible. Some people or classes of people may be so far below any reasonable threshold that caution will not prevent us from providing for special legal treatment. But if lawmakers take liberty se-

riously and recognize that the fundamental issues are legal, they must consider the evidence very carefully and must take responsibility for making the normative choice to treat crazy persons specially. The basic assumptions surely mean that we cannot differentiate crazy people simply on the basis of a label, "mental disorder," or on the basis of the question-begging assumption that "they must be nonresponsible because they're sick." Furthermore, no matter how precisely we define the class of mentally disordered people, there will be substantial differences among the people in the class that will require carefully individualized decision making in all legal contexts. The assumptions also enjoin us to find least restrictive means to respond to those situations in which we are confident about our judgments of nonresponsibility. Finally, the assumptions mean that we should be extremely hesitant to intervene in a person's life against his or her own wishes and for what we believe to be his or her own good. If we do intervene paternalistically, we should be certain not only that the means chosen are the least intrusive, but also that they are reasonably sure to produce the benefit that the person would have wanted for him or herself.

III. How Different Are Crazy People?

The most radical move one can make to support the general thesis that crazy people *are* responsible and should *not* be treated specially is to claim that mental disorder is a myth, a claim most famously argued in the provocative work of psychiatrist Thomas Szasz.[14] Although I agree with some of the conceptual criticisms of mental health science and many of the political criticisms of mental health law made by those who consider mental illness a myth,[15] I do not share their basic premise. Crazy behavior, however one wishes to conceptualize it, exists, causes suffering and disability, and sometimes may deprive the crazy person of responsibility. Nonetheless, as a normative matter, the law should design and interpret mental health laws to assure narrow application. In a society that prefers liberty, the class of people the law treats specially should be small,

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14. T. Szasz, The Myth of Mental Illness (1974).

15. *See especially* T. Szasz, Law, Liberty and Psychiatry (1963) and T. Szasz, Insanity: The Idea and Its Consequences (1987).

and legal decision making should err on the side of responsibility.

No human being is perfectly rational, and all are subject to conditions that on occasion make the choice to behave correctly or appropriately difficult. Nonetheless, we assume that most of us are capable of behaving rationally or resisting the desire to behave wrongly in difficult situations. Although these capabilities vary substantially among normal people, we assume that even the least capable normal person can behave minimally rationally with a reasonable amount of effort. The informal social and formal legal criteria for responsibility are not difficult for most people to attain under most circumstances. Thus, a normal person is considered to be responsible even if he or she behaves irrationally or is faced with and yields to most hard choices. By contrast, when crazy people behave irrationally or are swayed by the hard choices that their impulses may produce, we assume that they are not capable of behaving rationally or of mastering the desire to behave as their impulses predispose. We believe that anyone who behaves sufficiently crazily must be incapable of responsible behavior because no one who could behave otherwise would behave so crazily.

The capability for responsible behavior varies along a continuum. At the extremes, we can be quite sure of our judgments: the consistently rational person whose every action bespeaks firmness of self-control is of course capable of responsible behavior, and the person who behaves consistently and severely crazily is not. The hard question, as always, for legal policymakers and legal decisionmakers is where to draw the line. Which class of crazy people and which individual persons are so crazy that we may justly assume that they are not capable under any reasonable set of conditions of responsible behavior? There are no scientific answers to either of these questions, but there is relevant empirical evidence available to inform normative legal decisionmakers. On the basis of this evidence, I conclude that the vast majority of crazy people, including many who are severely crazy, are capable of behaving minimally rationally or resisting hard choices.

Considering the responsibility of crazy people requires examination of the total range of their behavior, including their noncrazy behavior, and comparison of it to normal peoples' behavior. Unless

one does so, it is too easy to conclude that crazy people are uniformly crazy and cleanly distinguishable from those considered normal. I shall consider the following types of evidence: clinical observations of crazy people, empirical research comparing crazy people to normals, and empirical research bearing directly on the rationality and normality of crazy people. If crazy people are not as different from normal people as one might suppose, and if crazy people demonstrate a great deal of normal, rational behavior, then perhaps they are more capable of responsible behavior than we usually assume, and thus the law should treat them less specially.

First, it is a striking clinical commonplace that crazy people, including the craziest, behave normally much of the time and in many ways. Even when they are in the midst of a period of crazy behavior, much of their behavior will be normal.[16] Between crazy periods, crazy people are not reliably distinguishable from normal persons. As a general matter, then, crazy people are by no means constantly crazy, nor are all their behaviors crazy, and even when behaving crazily, much of their behavior will be normal. Simple observation thus confirms that even the craziest people retain substantial capability to behave relatively normally.

Nonetheless, some crazy people occasionally may be incapable of behaving rationally. If one looks at the behavior and life histories of these people, there is apparently no other way reasonably to construe some of their conduct. But we cannot reach this conclusion simply because the person is diagnosable and may exhibit substantial crazy behavior. We must examine the total range of a person's behavior. We assume on the one hand that no one capable of rationality would behave so crazily; but on the other hand, there is much normal behavior to give us pause. At the least, it is unjustified to assert that crazy people as a class lack *all* capability for normal rational behavior.

Second, much of the empirical research on craziness has attempted to demonstrate that the performance of crazy people and

16. *See* Lehmann & Cancro, *Schizophrenia: Clinical Features*, in 4 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 680, 681-82 (H. Kaplan & B. Sadock eds. 1985).

normals differs on a wide variety of variables. For our purposes, studies that compare crazy people and normals on behavioral tasks are most relevant because physical and other differences are legally relevant only if expressed in behavior. People who behave rationally do not become nonresponsible simply because a physical variable systematically differentiates the diagnostic class to which they belong from other classes of responsible and non-diagnosable people. This is true even if the physical attribute that distinguishes crazy people is abnormal according to a coherent biological or medical concept of abnormality. Rationality, not biological normality, is the touchstone of legal responsibility, and rationality is a behavioral criterion that is not vitiated merely by the presence of a biological abnormality.

It is impossible to review all the studies that have compared crazy people and normals, but a recent review reaches what I believe are still representative results. Two well-respected researchers, Theodore Sarbin and James Mancuso, reviewed 374 studies of people diagnosed as suffering from schizophrenia that appeared between 1959 and 1978 in *The Journal of Abnormal Psychology* and its predecessor, *The Journal of Abnormal and Social Psychology*.[17] Sarbin and Mancuso chose these journals because they are prestigious journals with high standards for accepting manuscripts that publish the best efforts in the science of abnormal psychology.

Sarbin and Mancuso heavily criticize both the methodology of many of the studies reviewed and the conceptual status of the category of schizophrenia as a disease. Nonetheless, their most interesting conclusions are those derived from a large group of studies that accept or at least employ the disease category, schizophrenia, and that compare the differences in performance between those diagnosed as suffering from schizophrenia and those considered normal. In brief, Sarbin and Mancuso conclude that although there are small mean differences that favor the normals, "from inspection of the data, it is abundantly clear that most persons identified as schizophrenics do not function differently from most persons identified

17. T. SARBIN & J. MANCUSO, SCHIZOPHRENIA: MEDICAL DIAGNOSIS OR MORAL VERDICT? 22-51 (1980).

as nonschizophrenics."[18] In other words, the distributions of schizophrenics and nonschizophrenics on the tested variables overlap substantially. Moreover, the variability of the schizophrenics' scores is greater than that of the variability of the nonschizophrenics' scores. Sarbin and Mancuso conclude that "the single most reliable prediction to be made in studies of schizophrenics and nonschizophrenics" is that "the variability of the scores of schizophrenics will be observably larger than the variability of the scores of control samples," and that "most experimental measures have shown that schizophrenics are very different one from the other."[19] In light of the overlap of the two populations and the greater variability of the performance of schizophrenics, Sarbin and Mancuso conclude that the small differences in sample means do not mean that schizophrenics differ from normals. In sum, "one could not tell the 'sick' from the 'well' by the scores on the dependent measures [the tested variables]."[20] Moreover, if one subjects the studies from which these conclusions are drawn to a complete methodological critique, the conclusion that there are substantial differences becomes weaker still because there are sufficient flaws to warrant substantial caution about the conclusions.

The studies Sarbin and Mancuso reviewed dealt only with schizophrenia and used pre-DSM-III criteria[21] for identifying those diagnosed as suffering from schizophrenia. DSM-III's diagnostic criteria are narrower than those of its predecessors, and thus one might expect the differences to be greater in studies performed after the 1980 adoption of DSM-III. On the other hand, many post-1980 studies still use non-DSM-III criteria, and my review of the more recent literature, although not as complete or systematic as Sarbin and Mancuso's, provides no reason to believe that their primary

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18. *Id.* at 47.

19. *Id.* at 50 (emphasis in original).

20. *Id.* at 51.

21. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. 1980) [hereinafter DSM-III] includes the diagnostic criteria for all the mental disorders currently identified by the APA. DSM-III's diagnostic criteria are far more explicit than those of its predecessor, DSM-II (1968). A revised version of the third edition, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. rev.) was published in 1987 [hereinafter DSM-III-R]. Publication of DSM-IV is anticipated in the 1990's.

conclusions are now invalid. I also suggest that their conclusions—small mean differences, high intragroup variance, substantial overlap of distributions—hold for the smaller number of studies that compare other diagnostic groups, such as those suffering from affective disorders, to normals.[22] Further, most of the behavioral deficits present in disordered persons are common in normals as well.[23] Finally, Sarbin and Mancuso suggest that "disguised variables" that were not and still are not controlled for in most studies could account for most of the differences that do exist.[24] These disguised variables, such as socioeconomic status, are not the types of variables that bear on responsibility. Thus, even if they, rather than mental disorder, account for the measured differences, this would not indicate that the mentally disordered are distinguishable in legally relevant ways.

Almost none of the studies Sarbin and Mancuso review or others to which I refer address differences in genetic, biochemical, neurological, or other biological variables. Recent literature contains many studies that find such differences and conclude that there are real biological differences between normals and various types of disordered people.[25] Although many of these studies may have meth-

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22. *See, e.g.*, Layne, *Painful Truths About Depressives' Cognition*, 39 J. CLINICAL PSYCHOLOGY 848 (1983). *But see, e.g.*, Dobson & Shaw, 10 COGNITIVE THERAPY & RES. 13 (1986). Again, the point is not that there are no differences or that the mentally disordered suffer no deficits; rather, it is simply that the differences are much less significant than we commonly assume.

23. Harrow & Quinlan, *Is Disordered Thinking Unique to Schizophrenia?*, 34 ARCHIVES GEN. PSYCHIATRY 15, 19-21 (1977); Lehmann & Cancro, *supra* note 14, at 681. Moreover, when schizophrenics show greater thought disorder than normals, in some cases the cognitive defect can be easily modified, leading to the possible conclusion that thought disorder is not a valid indicator of schizophrenia. K. SALZINGER, SCHIZOPHRENIA: BEHAVORIAL ASPECTS 64-65 (1973). *See also* King & Sheridan, *Problem-Solving Characteristics of Process and Reactive Schizophrenics and Affective-Disordered Patients*, 94 J. ABNORMAL PSYCHOLOGY 17 (1985) (study failed to find, contrary to usual finding, that there are not cognitive deficiencies specific to schizophrenia). The easy modifiability of much thought disorder also suggests that this type of abnormal thinking may not be beyond the person's rational control.

24. T. SARBIN & J. MANCUSO, *supra* note 17 at 52-80.

25. *E.g.*, Egeland, Gerhard, Pauls, Sussex, Kidd, Allen, Hostetter & Housman, *Bipolar Affective Disorders Linked to DNA Markers on Chromosome 11*, 325 NATURE 783 (1987); Wong, Wagner, Tune, Dannals, Pearlson, Links, Tamminga, Broussolle, Ravert, Wilson, Young, Malat, Williams, O'Tuama, Snyder, Kuhar & Gjedde, *Positron Emission Tomography Reveals Elevated D_2 Dopamine Receptors in Drug-Naive Schizophrenics*, 234 SCIENCE 1558 (1986). *See also* Hodgkinson, Sherrington, Gurling, Marchbanks, Reeders, Mallet, McInnis, Petursson and Brynjolfsson, *Molecular Genetic Evidence for Heterogeneity in Manic Depression*, 325 NATURE 805 (1987) (evidence for genetic heterogeneity of linkage, rather than a single locus, in manic depression).

odological flaws or have not yet been replicated,[26] I assume that valid differences may someday be discovered.[27] Nevertheless, such a discovery, even if the distinguishing biological variable were abnormal, would have no necessary relevance for *legally or socially* distinguishing crazy people from normals.[28] Biological variables are not *per se* the criteria for nonresponsibility. All behavior has some biological causes. The legal issue, however, is whether the person is sufficiently nonculpably irrational or compelled. Differences in biology simply do not bear on responsibility if the actor behaves reasonably rationally and without compulsion. If a person is sufficiently irrational or compelled to warrant special legal treatment, the failure to discover a biological abnormality does not mean that the person is responsible.

None of the empirical research discussed above, which compares crazy people to normals, directly measured rationality and compulsion. Therefore, its relevance in deciding whether the law should treat crazy people specially is limited. Nonetheless, it suggests that the behavioral differences between crazy and normal people are less pronounced than is usually supposed.

A third type of evidence relevant to the law's decision to treat crazy people specially is found in studies that appear to measure more directly the rationality of crazy people. These studies often use as subjects hospitalized crazy people, those who are typically the most crazy. One series of studies deals with "impression man-

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26. *E.g.*, Farde, Wiesel, Hall, Halldin, Stone-Elander & Sedvall, *No D_2 Receptor Increase in PET Study of Schizophrenia*, 44 ARCHIVES GEN. PSYCHIATRY 671 (1987) (a team of Scandinavian researchers using equivalent methodology were unable to replicate the findings of Wong et al, *supra* note 23).

Despite increasing sophistication, "disguised" variables often are not controlled; studies use different diagnostic criteria for the same disorder, rendering the studies noncomparable; and there are still studies without sufficient reliability checks on the diagnosis of the disordered group. Further, even if the disordered subjects are reliably distinguished from normals for research purposes, the validity of the diagnostic categories is not established. DSM-III-R. *supra* note 19, at xxiv. It is not clear, therefore, that measurable differences measure the differences between normals and those suffering from a "real" disorder.

27. *But see* R. LEWONTIN, S. ROSE & L. KAMIN, NOT IN OUR GENES (1984) (reviewing the evidence for biological causation of a wide range of behaviors, including intelligence and schizophrenia, and concluding that the widely assumed biological determinist case is unproven now and is unlikely to be proven in the future).

28. *See* Morse, *supra* note 6, at 48-50, 71-76.

agement," the ability of people to manipulate their own behavior to attain their goals.[29] In the case of disordered people, researchers studied hospitalized patients' attempts to vary their degree of craziness in order to manipulate hospital personnel. For example, many mental patients, even quite crazy ones, are able to convince hospital staff that they are either more or less crazy in order to remain in hospital, to gain privileges, or to be released.[30]

Some patients who engage in impression management may be unaware of their manipulations, a possibility that has led commentators to claim with some justification that such unselfconscious behavior is not evidence of a patient's ability to cope rationally with the environment. Even if some patients lack such awareness, a not unreasonable supposition, this argument proves too much. The inability to be aware of or correctly to identify one's "real" reasons for action is endemic among people generally[31] and is hardly evidence of irrationality. There is no convincing evidence that crazy people especially lack the ability correctly to identify their "true" reasons for action. Even if they do, the class of people considered irrational would expand considerably if the lack of ability to know one's "real" reasons for action was a criterion for rationality. Indeed, some researchers claim that awareness and correct identification of the causes for one's actions are much rarer than we assume.[32] The unselfconscious ability to manipulate the environment successfully might be a sign of high social competence. Finally, it is simply not clear in impression management studies that the patients are unaware of what they are doing; much of the behavior is consistent primarily with the hypothesis that they are aware of their manipulations. The phrase chosen to describe the behavior, "impression management," connotes conscious and rational reasons for action.

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29. B. SCHLENKER, IMPRESSION MANAGEMENT: THE SELF-CONCEPT, SOCIAL IDENTITY AND INTERPERSONAL RELATIONS (1980).

30. B. BRAGINSKY, D. BRAGINSKY & R. RING, METHODS OF MADNESS: THE MENTAL HOSPITAL AS A LAST RESORT 49-74 (1969).

31. R. NISBETT & L. ROSS, HUMAN INFERENCE: STRATEGIES AND SHORTCOMINGS OF SOCIAL JUDGMENT (1980); Wilson, *Self-Deception Without Repression: Limits on Access to Mental States*, in SELF-DECEPTION AND SELF-UNDERSTANDING 95, 99-101 (M. Martin, ed. 1985).

32. *Id.*; Nisbett & Wilson, *Telling More Than We Know: Verbal Reports on Mental Processes*, 84 PSYCHOLOGICAL REV. 231 (1977).

Other research bearing on the rationality of crazy people involves "token economies," behavior modification regimes wherein subjects—mental patients in this case—are rewarded for approved behavior by being given tokens such as points or poker chips.[33] The tokens can then be used to purchase desired goods or increased privileges. Token economies are often effective; patients do change their behavior in planned, desired ways. Although derived from and cast in the theoretical terms of behavioral psychology, token economies can also be characterized as positing a rational, economic theory of human behavior. Studies of the operation of economic principles in these programs have found that patients respond to changes in relative prices and wages as economic theory predicts that rational, normal people respond; that is, patients conform to rational choice models by maximizing their expected utilities.[34] The effectiveness of token economies and their conformity to "rational person" economic models is further evidence that crazy people are capable of behaving rationally and that they respond to the same incentives as normal people. One must be careful about claiming too much on the basis of these studies because infrahuman species have also been shown experimentally to behave economically "rationally."[35] Studies of human subjects, however, do demonstrate mental patients' quite substantial capacity for rational, rule-following behavior.

Less rigorous observations in mental hospitals of patient management and governance programs provide related evidence about patients' capability to act rationally. Wards without token economy programs also have rules and procedures that patients are expected to follow; patients are expected to understand the rules and to play by them. If a patient who begins to threaten violent conduct is warned that she will be put in seclusion unless she calms down, the

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33. T. AYLLON & N. AZRIN, THE TOKEN ECONOMY: A MOTIVATIONAL SYSTEM FOR THERAPY AND REHABILITATION (1968).

34. Fisher, Winkler, Krasner, Kagel, Battalio & Basmann, *Implications for Concepts of Psychopathology of Studies of Economic Principles in Behavior Therapy*, 166 J. NERVOUS & MENTAL DISEASE 187, 191-93 (1978).

35. Kagel, Rachlin, Green, Battalio, Basmann & Klemm, *Experimental Studies of Consumer Demand Behavior Using Laboratory Animals*, 13 ECON. INQUIRY 22 (1975).

staff member is treating the patient as a rational maximizer. Similarly, patient self-governance programs assume that patients are capable of setting and enforcing the behavioral rules. Patients do indeed understand and play by the rules; otherwise, ward management would be impossible.

The final type of evidence that is directly relevant to crazy peoples' capability for rational action is found in studies of the behavior of disordered people in a variety of real world contexts, such as driving, holding jobs, managing finances, and responding to situations eliciting altruism.[36] The general outcome of these studies is consistent with the results of research on "laboratory" tasks. Crazy people are better able to perform real world tasks than we usually assume, and their behavior is often indistinguishable from the behavior of normal people.[37] Further, studies of social skills training demonstrate that socially disabled crazy people can learn to be socially competent.[38]

In sum, a great deal of evidence indicates that crazy people are capable of behaving rationally and that their behavioral capabilities are not as different from those of normals as we commonly believe. I do not contend that people who are considered crazy, especially those considered very crazy, are not different from people who are considered normal. Some crazy people do seem totally or near totally different. It is simply unbelievable to most observers that people

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36. *E.g.*, Armstrong & Whitlock, *Mental Illness and Road Traffic Accidents*, 14 AUSTL. & N.Z. J. PSYCHIATRY 53 (1980); Vecchione v. Wohlgemuth, 377 F. Supp. 1361, 1367-69 (E.D. Pa. 1974) (mental disorder not inconsistent with competence to manage finances); Howard, *The Ex-Mental Patient as an Employee: An On-the-Job Evaluation*, 45 AM. J. ORTHOPSYCHIATRY 479 (1975); Tolor, Kelly & Stebbins, *Altruism in Psychiatric Patients: How SociallyConcerned Are the Emotionally Disturbed?*, 44 J. CONSULTING & CLINICAL PSYCHOLOGY 503 (1976) (in a devised situation that subjects thought was real, psychiatric patients demonstrated more altruism than normals; no differences found in a paper and pencil task).

37. *See 1 in 5 Adults Lacks Basic Living Skills*, L.A. Times, Oct. 30, 1975, pt. 1 at 1, col. 1 (reporting a large-scale University of Texas study). I am not claiming that all mentally disordered people are competent and that a larger percentage of normals than crazy people is not. Once again, the claim is simply that the disordered are far less distinguishable than is usually believed.

38. Brady, *Behavior Therapy*, 4 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1365, 1372-73 (H. Kaplan & B. Sadock eds. 1985); Brown & Munford, *Life Skills Training for Chronic Schizophrenics*, 171 J. NERVOUS & MENTAL DISEASE 466 (1983); Hansen, St. Lawrence & Christoff, *Effects of Interpersonal Problem-Solving Training With Chronic After-care Patients on Problem-Solving Component Skills and Effectiveness of Solutions*, 53 J. CONSULTING & CLINICAL PSYCHOLOGY 167 (1985).

who are delusional and wildly out of touch with reality, for example, are capable of behaving rationally when their behavior is affected by the delusions. On the other hand, even in cases of the most extreme disorder, we cannot be certain that such people are incapable of minimal rationality (although it might take great effort for them to behave rationally). In the case of most crazy people, the evidence supporting broad claims about their incapacity to behave rationally is equivocal—little more than an intuitive hunch.

Again, I do not mean to make an absurd claim. A chronically disabled, hallucinating, and delusional person who wanders the streets in rags speaking gibberish is not "like" normal persons, and the law should probably treat this person specially. Nevertheless, the law should be far more cautious before concluding that large numbers of crazy people are so incapable of responsible behavior that deprivation of liberty is justified.

I am trying to shift the burden of persuasion on this issue. If we simply assume what "everyone" assumes—that crazy people are generally incapable of responsible behavior—then we do not need evidence or arguments to support this assumption as a predicate for social and legal policy. I am suggesting, however, that in this case, the common wisdom is supported primarily by intuition and assertion. Contrary evidence and arguments do exist. Such contrary data and arguments do not prove that the common wisdom is wrong and that almost all crazy people should be treated just like everyone else. The common wisdom is not scientifically proven, however, and society and the law should hesitate before acting on it. If we wish to treat crazy people differently, let us do so honestly, without pseudoscientific rationalizations. Furthermore, as the next section will suggest, rather than treating crazy people as different and "other" we should redefine our expectations and many institutions to facilitate the integration of crazy people into the mainstream of society.

IV. Normative Suggestions for Normal Treatment of Crazy People

Let us assume, as we now do, that substantial numbers of crazy people are incapable of behaving rationally and that the law is con-

sequently prima facie justified in treating at least some of them specially. Even so, there are good reasons and better methods for treating crazy people less specially than their "differentness" might theoretically permit. The methods and arrangements that I propose will not be utopian and cost-free. When we consider social change, and especially when we resist it, it is easy to forget that no social policies, including the present ones, are ideal. If the law treats crazy people less specially, some will be forced to suffer consequences of their craziness that we should not wish them to bear. A truly unfair contract may be enforced; a desperately needy person may not receive treatment. On the other hand, present policies brand an entire class of people as unworthy of the full responsibilities of autonomous personhood, fail to achieve their stated purposes, and in an enormous number of specific cases, incorrectly deprive people of liberty or deem them nonresponsible.

Confronting honestly the costs of present arrangements is especially useful when special legal treatment is paternalistically premised. We should not intervene in the lives of others for their own good, especially if doing so requires substantial intrusions on liberty, unless we can be quite sure that we will actually improve the lot of those we aim to help.[39] Good motives should not lull us into complacency about the benign consequences of paternalistic action; instead, we should be skeptical about whether we have done the best we can. We should be especially skeptical about the priority of our motives when we are dealing with a class of people, such as the mentally disordered, who are feared and despised more often than they are treated with sympathy and concern.

With these general considerations in mind, let us turn to specific suggestions for treating crazy people less specially. Our society generally prefers maximizing liberty, even at the cost of increased social danger and other social harms. For instance, our criminal justice system favors incorrect acquittals to incorrect convictions, and the length of a prison term is limited by the offender's desert. Consequently, dangerous and guilty defendants are acquitted, and clearly

39. *See* J. KLEINIG, *supra* note 11, at 74-77.

dangerous prisoners are released at the end of their prison terms.

In effect, our society and the law have decided that liberty is worth substantial social risks. I believe we should adopt this attitude more extensively in our treatment of crazy people.Most mental health professionals and legal policymakers, including the majority of those who are most paternalistic, favor substantial liberties and legal protections for crazy people. Nevertheless, I think the law can "take more risks" with crazy people at far less cost than we are willing to bear in other contexts such as the criminal law. The degree of risk that society should be willing to accept might vary from one mental health law context to another; the policies underlying laws regulating competence to contract, on the one hand, and involuntary commitment, on the other, for example, may require different results. But the preference should always be for less special treatment and more risks.

The law's related assumptions that crazy people cannot fully appreciate liberty and that their problems are primarily medical or psychiatric have led to uncreative responses to the social problems that crazy behavior produces. If the law focused more strongly on protecting and promoting the liberty of crazy persons, more creative social solutions might result. For example, some people are homeless because mental disorder renders them incompetent to manage the simplest affairs of everyday life. Although homeless people are not all crazy and some who are crazy are not homeless *because* they are crazy, some cases of homelessness are produced primarily by craziness.[40]

Until about twenty-five years ago, the traditional viewpoint was that homelessness among the mentally disordered was primarily a medical problem that should be solved by committing the person-

40. All the homeless are not mentally disordered and the causes of homelessness are hardly clear, but it is virtually certain that some small fraction of the disordered homeless are homeless primarily, if not entirely, because of disabilities stemming from their disorder. *See* C. KIESLER & A. SIBULKIN, MENTAL HOSPITALIZATION: MYTHS AND FACTS ABOUT A NATIONAL CRISIS 199-202(1987) (good data on the homeless are surprisingly sparse; estimates of the percentage of homeless who are mentally disordered vary widely; common assumption that homelessness among the mentally disordered is produced by deinstitutionalization is incorrect).

involuntarily to a mental hospital.[41] But we can also treat homelessness as an essentially socioeconomic problem and we should remember that a hospital is not a home. There are not many rich crazy homeless people because the wealthy have the resources to permit adequate care and treatment without inpatient hospitalization. Few rich crazy persons are sleeping on inner city subway grates. Indeed, it is possible with proper allocation of resources and creative community institutions to treat adequately almost all mental patients without hospitalization or with brief hospitalization at most.[42] Now, if involuntary hospitalization, especially on a long-term basis, is difficult to accomplish, society will be forced generally to attempt the less intrusive alternatives that now are readily available only to wealthier people or in a few fortunate communities[43] (or to admit its hypocrisy about claims about caring for poor mentally disordered people). My point is not that this is the appropriate response to this particular problem, although I think it is; rather, the limited point is that a sincere desire to treat crazy people less specially can often produce a successful social and legal solution with less deprivation of liberty. At the very least, if we know that less intrusive solutions are possible, it is more difficult to assume that an intrusive mental health law is justified, even if we ultimately adopt it.

Focusing on treating crazy people less specially can produce a desirable shift in social and legal policy by causing reconsideration of the determinants of competence. Most mental health laws deprive a person of liberty or autonomy because the person is incompetent, broadly speaking, to perform one task or another. In the case of crazy people, we assume that an *intra*personal variable, craziness, produces the incompetence, but this is an oversimplification. A per-

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41. Westermeyer, *Public Health and Chronic Mental Illness*, 77 AM. J. PUBLIC HEALTH 667 (1987).

42. C. KIESLER & A. SIBULKIN, *supra* note 40, at 152-80. A recent feasibility study concluded that Vermont could dismantle its state hospital system entirely and improve the population's quality of mental health care through the use of community-based treatment. Carling, Miller, Daniels & Randolph, *A State Mental Health System With No State Hospital; The Vermont Feasibility Study*, 38 HOSP. & COMMUNITY PSYCHIATRY 617 (1987). *But see also*, Kincheloe & Ettlinger, *Commentary: A False Dichotomy*, 38 HOSP. & COMMUNITY PSYCHIATRY 623 (1987).

43. *See* S. ESTROFF, MAKING IT CRAZY: AN ETHNOGRAPHY OF PSYCHIATRIC CLIENTS IN AN AMERICAN COMMUNITY (1981), for an extensive description of a successful program of community care.

son's competence to perform any task is clearly a product of the interaction between the person's cognitive and physical abilities, the inherent difficulty of the task, and situational variables that may affect either the person's abilities or the difficulty of the task. Virtually anyone, no matter how personally capable, can be rendered incompetent to do anything if he or she is placed under sufficient kinds of the appropriate stress. Conversely, even extremely "incompetent" persons can be made more competent by a combination of personal supports and by redesigning or redefining the necessary tasks.[44] For example, physically handicapped persons are able to fulfill the demands of otherwise impossible roles if they are given various forms of rehabilitation and if the environment is redesigned to allow performance of those roles. If office buildings are made accessible to those in wheelchairs, physically handicapped persons may be able to hold jobs not previously available to them. The situation is similar for many mentally disordered people. Provision of social skills training and social supports to simplify life tasks can enable seemingly disabled people to live reasonably independent lives.[45]

Replying simply that such suggestions are unrealistic or that they presuppose an inappropriate definition of a task or an environment begs the question. One may properly argue that society should not spend the resources to ensure lives of greater liberty and independence for crazy people because such resources would be better spent in other ways. Or one may suggest that the present set of social expectations or arrangements is justified on (specified) normative grounds. But it is misleading to claim that only one set of solutions is feasible or "proper."

Too often social tradeoffs and normative justifications are overtly or covertly hidden behind unjustified assertions of the latter type. For example, group homes attended by social service personnel might enable many crazy people to lead lives of reasonable liberty and dignity in the community. Perhaps we do not wish to pay the short term capital and other costs of constructing such homes in decent

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44. *See Minow*, *supra* note 5, at 184-87.

45. *Id.*; C. KIESLER & A. SIBULKIN, *supra* note 40, at 152-80.

areas because we would rather spend the money elsewhere or perhaps we do not wish such homes in "our" neighborhoods, even if they are affordable. If so, let us openly admit these reasons, let us admit we prefer to exclude the disordered as "other," rather than hiding behind the rationalizations that we simply cannot afford such homes, that they cannot succeed, or that hospitals are the appropriate places for "sick" people.

Less intrusive means for solving social problems created by mental disorder will routinely be available and may often be cheaper than more legally intrusive methods. In the long run, group homes will be cheaper than hospitals, for example.[46] Nonetheless, a vision of the problems that assumes the validity or inevitability of present responses will diminish the possibility of discovering and designing responses that enhance freedom and achieve other social goals, including the integration into society of the mentally disordered.[47]

Another reason to limit differential treatment of crazy and normal people is that broad mental health laws are often used inappropriately and indirectly to achieve allegedly desirable results by unjustifiably permitting normal people to be deprived of autonomy or to evade responsibility on grounds of craziness.[48] For example, assume a wealthy decedent left all her money to a "fringe" organization and impoverished her "deserving" family.[49] Such a will would strike many people as unfair to the family, but how can the law prevent this disposition of the property in the face of the strong social policy favoring testamentary independence? A classic means

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46. *See* C. KIESLER & A. SIBULKIN, *supra* note 40, at 179.

47. Allocating resources for special services for mentally disabled people may seem inconsistent with the argument in Section III that the law should not treat disordered people as specially as it now does. The possible asymmetry is not troubling, however, because the justification for disadvantageous special treatment ought to be far weightier than the justification for humane special treatment of needy people. Some might argue that present special legal treatment, such as involuntary commitment, is generally advantageous to disordered people, but as I have tried to demonstrate in this article and elsewhere, this argument is unpersuasive. *See, e.g.*, Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54 (1982).

48. The classic analysis of this problem is Green, *Proof of Mental Incompetency and the Unexpressed Major Premise*, 53 YALE L.J. 271 (1944).

49. This was the situation in *In re* Strittmater's Estate, 140 N.J. Eq. 94, 53 A.2d 205 (1947), where the ardently feminist decedent left all her money to a radical feminist organization. Needless to say, the relatives tried to break the will.

for invalidating such wills is to find on the basis of psychiatric testimony that the testator was incompetent to make a will.[50] The law may then reach the preferred result without questioning the general policy, but doing so involves a dishonest and degrading legal fiction. If we wish to override testamentary independence on distributional or justice grounds, we should face this issue and pass appropriate laws.

Now consider the following example of how mental disorder may be used illegitimately to evade responsibility.[51] Suppose that a businessperson fails to file federal income tax returns for a number of years. Assume that she has a hitherto unblemished record and that she was the sole support of her model family. Assume further that she was under a great deal of financial strain and intentionally decided to chance not filing the returns. In this case, criminal prosecution for tax evasion is fully justified but not appealing; the potential defendant has no record, is an otherwise productive member of the community, is the sole support of her family, and has the resources to mount a defense that will be both difficult and expensive for the government to overcome. Failing to prosecute on those grounds is an admission of the disparities in treatment the law metes out to the rich and poor. If the defendant can claim that the strains on her produced mental disorder, then this nice middle-class person and her family and friends need not consider it a case of dishonesty, and the IRS has a more class-neutral ground for pursuing civil rather than criminal remedies. Once again, however, this solution allows society to avoid facing the hard question of prosecutorial policy that is really involved. If our general social and legal policy is questionable, it should be questioned directly and not evaded by using a claim of mental disorder to reach the preferred result in the individual case.

A final suggestion for treating crazy people less specially applies when the law acts paternalistically, that is, when the law forcibly intervenes primarily for the good of the mentally disordered person.

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50. The judge in *Strittmater* did exactly this, finding that the decedent's radical feminist views were a product of mental disorder.

51. The following example is based on a real case from my consulting practice.

I suggested earlier and more generally that we should be very cautious before intervening paternalistically.[52] In addition, when the law decides that paternalistic action is justified, it should apply a subjective standard for the substitution of judgment.[53] A subjective standard requires the decisionmaker to ascertain and order what the crazy person would have decided and done for himself or herself under the circumstances if he or she had been acting competently. By contrast, the objective standard asks the decisionmaker to ascertain and order the course of harm-preventing or good-promoting action that a hypothetical reasonable person would have chosen. The subjective standard is preferable because it does not impose possibly alien values upon the crazy person and thus is a less objectionable intrusion on liberty and dignity. The subjective standard respects the integrity of the person's reasonably settled values, preferences, and goals. Most persons in a free society would prefer that when others act for us, they should do for us what we would do for ourselves.

Making the subjective determination may be difficult, because the crazy person seldom will have given prior specific indication of what he or she would do under specific circumstances, especially if he or she has not previously encountered those circumstances. This objection is unconvincing, however, because there often will be specific indication of the person's wishes. Even if there is no such indication, empathetic identification with the person should help the decisionmaker to reconstruct the person's value preferences and to predict what he or she would have decided.[54] If there is insufficient evidence of what the person's preferences would have been under the circumstances, the decisionmaker must apply the objective standard. But the subjective standard should not be rejected in individual cases because the person's identifiably settled preferences, expressed at a time when he or she was responsible, seem odd, idiosyncratic,

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52. *See supra* text accompanying notes 8-13.

53. *See* D. VANDEVEER, PATERNALISTIC INTERVENTION: THE MORAL BOUNDS OF BENEVOLENCE 390-93 (1986) (discussing the various standards for substitution of judgment). Only a brief sketch of this very complicated issue is possible here.

54. *But see* Dworkin, *Autonomy and the Demented Self*, 64 MILBANK Q. 4, 13-14 (1986) (arguing that speculation about what an incompetent person would have preferred under assumed conditions of competence may be relevant to determining the person's best interests, but that such speculation is not a proper foundation for respecting autonomy).

or strange. In a pluralistic, liberty-preferring polity, we must respect each other's preferences, even if we disagree with them.

Applying the subjective standard is more expensive and time-consuming, but the decreased intrusion on the person's life justifies the cost. If the subjective standard is too costly, we should be even more cautious about behaving paternalistically. The intrusion is enormous, and we greatly risk not improving the crazy person's lot according to his or her own standards. At the least, we should recognize and justify the costs of acting paternalistically on an objective basis.

One may question pleas for the expenditure of effort, time, and money to treat crazy people less specially by pointing to our policies toward children. Because minors as a class are considered less rational and responsible than adults, few people object to systematically special legal treatment of children. If one analogizes people under the sway of craziness to minors on the ground that immaturity and craziness similarly render people incompetent, it may seem that differential legal treatment is also justified for crazy people.

But minors and crazy adults are different in crucial respects. First, virtually all crazy people will have shown for substantial portions of their adult lives the capacity for full legal responsibility and competence. Second, they will have achieved both the wisdom that experience teaches—at least to the extent that anyone achieves such wisdom simply by the passage of time—and the longer time-horizons that development provides. Children do not achieve these conditions by definition, and there is little reason to believe crazy adults achieve them substantially less than normal adults.

Third, we can discern an adult's settled preferences and values with reasonable confidence, but children's preferences and values are less formed and in flux. Fourth, paternalistic intervention with children largely takes place under the direction of parents and parent-substitutes such as teachers who can generally be trusted to act in the child's best interests. By contrast, strangers and state representatives perform most of the paternalistic intervention in the lives of adults. Sociological and historical studies show that paternalism by strangers is rarely motivated by the subject's best interests and

is far more likely to lead to harm.[55] Indeed, when conflict arises in intimate relations—when family members become "strangers" to some degree, for example—we least trust paternalistic motives even in such contexts. Fifth and last, even children are often treated less paternalistically when their important interests, such as procreation[56] and free speech,[57] are in issue, and liberty and autonomy are especially important interests for adults.[58]

In sum, my plea is for liberty, creativity, and honesty in mental health law policymaking and adjudication. Even if very crazy people are somewhat less responsible than normal people, the law should try to preserve their liberty, autonomy, dignity, and integration in the community as much as possible consistent with sound social policy. The law should consider and pursue nonmedical and less intrusive legal alternatives that treat crazy people less differently. Intrusive mental health laws should be drafted narrowly to apply only to the smallest subset of the disordered for whom such laws are absolutely necessary. Finally, social policy trade-offs and dilemmas should be faced honestly and directly rather than evaded by assuming that only general medical solutions are possible or by accepting bogus claims of mental disorder in order to reach preferred results in individual cases.

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55. Douglas, *Cooperative Paternalism versus Conflictful Paternalism*, in PATERNALISM 171, 175-80 (R. Sartorius ed. 1983).

56. Carey v. Population Serv. Int'l, 431 U.S. 678 (1977); Planned Parenthood v. Danforth, 428 U.S. 52 (1976); *but see* H.L. v. Matheson, 450 U.S. 398 (1981).

57. Tinker v. Des Moines Indep. Community School Dist., 393 U.S. 503 (1969). *But see* Hazelwood School Dist. v. Kuhlmeier, 108 S. Ct. 562 (1988).

58. In Parham v. J.R., 442 U.S. 584 (1979), the Supreme Court held that no adversarial process is necessary when minors are placed in mental hospitals by their parents or guardians. Due process for the commitment is satisfied by the exercise of the professional judgment of the admitting physician. This decision places minimal constraints on paternalistic intervention in the lives of children when their physical liberty and autonomy are at stake, and is therefore a counterexample to the textual discussion. On the other hand, some state courts that have considered the issue have recognized that minors, especially older minors, deserve substantial procedural protection before their parents or guardians may commit them to mental hospitals. *In re* Roger S, 19 Cal. 3d 921, 569 P.2d 1286, 141 Cal. Rptr. 298 (1977). Furthermore, in recognition of the competence of older minors, many state statutes allow them to give independent informed consent to the receipt of specific or general medical services. Finally, many of the Court's empirical assumptions that grounded the decision in *Parham* were erroneous. Melton, *Family and Mental Hospital as Myths: Civil Commitment of Minors*, in CHILDREN, MENTAL HEALTH AND THE LAW 151 (N. Reppucci, L. Weithorn, E. Mulvey & J. Monahan, eds. 1984).

V. Procedural Policies

It is difficult to formulate general procedural policies because the procedural aspects of mental health law vary from context to context. The procedural requirements of an insanity defense trial in a capital case are different from those in a social security disability hearing. Nonetheless, a few pertinent general suggestions are in order.

Most important, the law should consistently treat mental health cases as serious legal cases that raise social, moral, and political issues. Legal formality should be preferred to informality or nonlegal decisionmaking, and full adversarial adjudication should be used when appropriate. Too often, mental health law cases are treated as essentially medical and, consequently, are not taken seriously. The allegedly crazy person is poor, powerless, and underrepresented; and the proceedings are far too informal to generate a full, individualized airing of the important issues involved. Involuntary commitment proceedings, in which the allegedly crazy person can be deprived of his or her liberty for substantial periods of time, provide a good example. These proceedings are typically brief and informal: the lay witnesses necessary for full evaluation of the case rarely testify; the allegedly crazy person even more rarely has an expert of his or her own; and the defense lawyers typically do not prosecute these cases with the "warm zeal" that the canons of ethics require.[59] An involuntary commitment trial need not be as procedurally encumbered as a criminal trial, but it should be as fully adversarial as, for example, a commercial claim for money damages.

Procedural formality is often viewed as an unjustified hindrance to achieving the essentially medical purposes of mental health law.[60] We have seen already, however, that no mental health law adjudicates essentially medical questions; all are concerned with fundamental moral, social, political and, ultimately, legal issues. Thus, all must be taken legally seriously. Moreover, in those contexts such

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59. C. Warren, The Court of Last Resort: Mental Illness and the Law 7-15, 137-54 (1982); Morse, *A Preference for Liberty*, *supra* note 47, at 76-79.

60. Addington v. Texas, 441 U.S. 418, 428-30, 432 (1979).

as involuntary commitment, in which the allegedly crazy person rarely has the resources to mount a full adversary presentation, there is great danger. Disfavored minorities, such as the mentally disordered, are far more likely to be the victims of prejudice in informal rather than formal proceedings.[61] Failure to individualize by reasonably adversary procedures dehumanizes the disordered person and increases the probability of incorrect decisions.

In recent years, however, the United States Supreme Court has demonstrated a disquieting readiness to treat mental health law questions as essentially medical and to refuse to impose the fullest possible procedural protections simply because the Court believes, mistakenly, that the issue at stake is medical. The trend began in *Addington v. Texas*,[62] in which the Court declined to impose on the state the burden of persuasion beyond a reasonable doubt in indefinite-term involuntary commitment cases. The Court asserted that the issues were primarily medical and depended upon expert interpretation of the facts. But whether a person's conduct and mental condition justify the involuntary deprivation of liberty is not a medical issue.

In *Parham v. J.R.*,[63] the Supreme Court deviated from a series of cases granting juveniles extensive due process protections. The Court held that when parents wish to commit their children to mental hospitals, due process is satisfied if the hospital's mental health professional agrees that hospitalization is justified. The Court was willing to limit a juvenile's rights not only, or even primarily, because parental rights were at issue—parental rights were at issue in procreation cases, too—but because the Court viewed the commitment of minors as a medical issue. The Court asserted that there was little reason to believe judges were better adjudicators of essentially medical questions than mental health professionals, and thus it deprived children of neutral, independent decisionmakers.

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61. Delgado, Dunn, Brown, Lee & Hubbert, *Fairness and Formality: Minimizing the Risk of Prejudice in Alternative Dispute Resolution*, 1985 WIS. L. REV. 1359, 1387-91.

62. *Addington*, 441 U.S. 418.

63. *Parham*, 442 U.S. 584.

But, again, whether a child can be totally deprived of liberty and stigmatized cannot be solely a medical question.[64]

In *Youngberg v. Romeo*,[65] the Court considered the substantive rights to liberty, safety, and habilitation of retarded inmates of a state institution and held that the state acted properly to protect those rights as long as professional judgment was exercised in managing the institution and devising individual treatment plans. Although *Youngberg* is not a procedural case, it essentially converted legal questions about the scope of patients' rights into questions that could be decided by mental health professionals on the basis of their mental health judgment.

Most recently, in *Allen v. Illinois*,[66] the Court considered whether the fifth amendment guaranteed a defendant in a quasi-criminal, sexual dangerousness commitment proceeding the right to remain silent. The Court held that because the purpose of the proceedings was to provide treatment, the usual protections of the criminal justice system need not apply. The Court disapproved of any unnecessary hindrances to ascertaining and interpreting the facts necessary to make what it viewed as primarily a medical decision. Once again, however, it is an error to decide the case by label rather than by serious consideration of what is at stake legally and politically. My point is not that the decision was necessarily wrong, although once again I think the decision was mistaken; it is simply that it is based on a mistakenly medical premise.

The central themes underlying all these opinions are that mental health law cases raise primarily medical or psychiatric issues, that strict procedural formalities are an unjustified obstacle to proper resolutions of the issues, and that mental health professionals are the best sources of providing and interpreting the facts and even of deciding the issues. These cases are unsettling because they reflect at the highest level a basic misunderstanding of the issues and be-

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64. As is so often true in mental health cases, the Court based its opinion on a number of factual assumptions that are simply unsupportable. *See supra* note 58.

65. Youngberg v. Romeo, 457 U.S. 307 (1982).

66. Allen v. Illinois, 106 S. Ct. 2988 (1986).

cause their outcomes are certain to decrease the welfare of mentally disordered people. In all contexts in which mentally disordered people are strangers, reducing the procedural barriers to treating them specially will ensure that they are treated specially in a more negative way.

To be more specific, allegedly crazy people should be represented in all contexts by counsel who should seek to accomplish what the client wishes, or, if the clients' wishes are unclear, to prevent intrusion on the clients' liberty. Some might argue that this will prevent the allegedly crazy person from receiving needed care, treatment, or protection from physical, financial, or social ruin. But an adversary system is premised on the assumption that the truth is best determined by a fully adversarial airing of the issues, and there is no reason to believe that the theory is less applicable in mental health cases. It is the duty of the state or any other party alleging that a person is crazy to prove that the criteria for the application of mental health laws are satisfied. In relatively clear cases, the moving party will be able to do so, even if it is opposed by active, competent adversary counsel. In less clear cases, good attorneys may cause the system to err by underapplying mental health laws. In unclear cases, however, this is precisely the preferable error in a society that prefers liberty and the presumption of personal responsibility. Indeed, the consequences of erroneous overapplication of mental health laws—deprivation of liberty, autonomy, and dignity—are the most serious that our legal system can produce. Finally, counsel who follow their clients' wishes respect the autonomy and dignity of their clients. This is how lawyers should behave, even if they believe that the clients' choices are wrong. If lawyers acted in all cases as they do in mental health cases, few clients would be represented well, because to represent clients effectively, lawyers must often actively argue positions with which they disagree.

In addition to requiring full adversarial representation by lawyers on both sides, mental health law cases should be decided primarily by judges, rather than by panels of laypersons or by mental health experts. Society can choose to delegate decisionmaking authority in such cases, but doing so would be a mistake. Judges can also conflate medical and legal issues, but they are best situated by training,

experience, and role definition to be neutral decisionmakers who recognize the moral and political nature of their legal tasks. Once again, the ultimate issues in mental health cases are not medical or scientific, and mental health professionals are not expert on the formal resolution of nonmedical issues. Society should not delegate essentially legal tasks to nonlegal decisionmakers. Additionally, as noted before, decreased formality in a decisionmaking process may cut time and cost, but only at the counteracting cost of substantially increasing the risk of prejudice toward disfavored minorities. The integrity of legal decisionmaking and the welfare of the disordered require that mental health cases should be decided by judges or other neutral legal decisionmakers.

Allegedly crazy people must also have access to mental health experts of their own, especially if the law fails to reform the rules and procedures for evaluating legal craziness. The United States Supreme Court recently ruled in *Ake v. Oklahoma*[67] that criminal defendants with a colorable claim of legal insanity were entitled to the services of a mental health professional to aid their defense, but this is not required in many mental health law contexts, including involuntary commitment and conservatorship proceedings. An allegedly crazy wealthy person can of course hire an expert, but an allegedly crazy indigent person cannot obtain the assistance of an independent professional unless the state pays for it. Because courts routinely view the issues as largely medical and defer to the sole expert that the state retains, it is crucial in proceedings where liberty is at stake for the allegedly crazy person to have his or her own witness. Providing advocate experts in the appropriate contexts will be expensive and may even encourage the battle of the experts, but these are the inevitable costs of deciding to treat crazy people specially to the detriment of their liberty and autonomy. If the scope of expert testimony is limited by relying on observations rather than on irrelevant diagnostic and legal conclusions,[68] the provision of ad-

67. Ake v. Oklahoma, 470 U.S. 68 (1985).

68. Morse, *Crazy Behavior, Morals and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 600-26 (1978); Morse, *Failed Explanations and Criminal Responsibility: Experts and the Unconscious*, 68 VA. L. REV. 971-83, 1044-59 (1982).

vocate experts will not create an even more unseemly battle of the experts than now obtains.

In those cases in which an advocate expert is not required by due process or is not available for other reasons, the court should be aware and should attempt to ensure that the jury recognizes that the sole expert is not impartial. The court should require that the sole expert be fully cross-examined. Judges should know and juries should be instructed that unopposed expert testimony should be assessed cautiously and that it may be disregarded entirely. I also suggest that a trial or appellate court should almost never overturn, as a matter of law, a jury or judge's decision on the ground that it is contrary to the weight of the *expert* evidence, even if the verdict disregards unanimous expert testimony to the contrary. A factfinder's decision should not be overridden under such circumstances because mental health law questions are primarily moral and social, not scientific. There can be no "weight of expert evidence" on the ultimate legal issue.

Vigorous, complete adversary procedures will not be a panacea in mental health law adjudication, especially if the law does not adopt necessary limitations on expert testimony, but they will promote greater honesty and integrity in decisionmaking and ensure that crazy people are treated specially only when such treatment is truly justified.